ATTACHMENT 5
Sample Prior Authorization Dental Request Form (PA/DRF) for oral surgery services

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11035 (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Dental Request Form (PA/DRF) Completion Instructions (HCF 11035A).

FOR MEDICAID USE — ICN	AT	Prior Authorization Number
		1234567

SECTION I — PROVIDER INFORMATION

1. Name and Address — Billing Provider (Street, City, State, Zip Code)	2. Telephone Number ? Billing Provider	3. Processing Type (Check one)
I.M. Provider **1 W. Williams** **Anytown, WI 55555**	**(XXX) XXX-XXXX**	☒ 124 (Dental) ☐ 125 (Ortho)
	4. Billing Provider's Medicaid Provider No. **12345678**	
	5. Performing Provider's Medicaid Provider Number **12345678**	

SECTION II — RECIPIENT INFORMATION

6. Recipient Medicaid ID Number	7. Date of Birth — Recipient	8. Address — Recipient (Street, City, State, Zip Code)
1234567890	**MM/DD/YY**	**609 Willow** **Anytown, WI 55555**
9. Name — Recipient (Last, First, Middle Initial) **Recipient, Ima**	10. Sex — Recipient ☐ M ☒ F	

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

11. Place of Service
☒ Dental Office (POS 11) ☐ Outpatient Hospital (POS 22) ☐ Ambulatory Surgical Center (POS 24)
☐ Skilled Nursing Facility (POS 31) ☐ Other (please specify): _____

13. Tooth No.	14. Procedure Code	15. Modifier	16. Description of Service	17. QR	18. Charge
	41010		**Incision of lingual frenum**	**1**	**xxx.xx**

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.

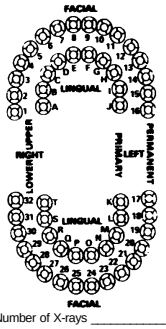
19. **Total Charges** **xxx.xx**

20. **SIGNATURE** — Performing Provider: I.M. Provider — 21. Date Signed: **MM/DD/YY**

22. **SIGNATURE** — Recipient / Guardian (if applicable) — 23. Date Signed

12. Dental Diagram

- Circle periodontal case type if applicable. I II III IV V
- Cross out missing teeth.
- Circle teeth to be extracted.



Staple X-Ray Envelope Here

Number of X-rays _____
Type of X-rays _____

FOR MEDICAID USE — Procedure(s) Authorized: — Quantity Authorized:

☐ Approved — Grant Date — Expiration Date

☐ Modified — Reason:

☐ Denied — Reason:

☐ Return — Reason:

_____ **SIGNATURE** — Consultant / Analyst — _____ Date Signed